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SCHOOL OF  
SOCIAL WORK



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Thesis  
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1949



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BOSTON UNIVERSITY  
SCHOOL OF SOCIAL WORK

RESEARCH AND DOCUMENTATION  
IN THE HISTORY OF THE  
SCHOOL OF SOCIAL WORK

A study of persons in middle years  
and their life and their need for  
to the Boston State Hospital

School of Social Work

June 15, 1949

2438

A Thesis

Submitted by

Lowell Thomas Griffin

B.A. in Social Work, 1947

in partial fulfillment of requirements for

the degree of Master of Social Work



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## Chapter I

## INTRODUCTION

With the exception of a few 'organic' psychoses, such as, general paresis and psychoses dependent upon the degenerative conditions of old age, surprisingly little is known of the etiology of the mental disorders. Several lines of evidence suggest that the 'functional psychoses', schizophrenia, involutional psychosis, cyclothymia and others, are in general dependent upon two types of causes. As in many other disorders we have to distinguish between the predisposing cause and the precipitating cause. That they arise only in soil previously prepared for them seems, on the whole, evident. It would appear that many individuals go through the most acute mental torment to emerge but the stronger for the experience, while others become psychotic with only<sup>1</sup> trifling antecedent emotional stress.

Psychiatrists are giving increased attention to the relationship between mental disorder and social environment. In an address delivered in 1926, William A. White pointed out the mutual advantages in an alliance of psychiatry with the social sciences. "Mental disorder as we ordinarily meet it", he said, "is a disorder of the individual at the level of

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<sup>1</sup> Madison Bentley, The Problems of Mental Disorder, McGraw-Hill Company, 1934, p. 234.

Chapter I  
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social adjustment." An interesting example of the interplay between a medical and a social art is afforded by the insight into individual personality which was psychiatry's great gift to social work, a contribution that was amply repaid by the insight into the cultural conditioning of personality supplied by social workers to psychiatrists.<sup>2</sup>

### Statement of the Problem

The purpose of this thesis is to make a study of the personality and social factors influencing involutional psychosis in middle life and later years.

The general focus of the study will be to show the relationship between the personality, social maladjustments, and traumatic experiences as they are reflected in the onset of the present illness in these patients. It will be found that no case presented shows any "one" cause, as there is an interaction among causes and results so that it is sometimes difficult to sort out cause from effect in specific situations.

The intention of the writer is to study the cases presented with a view toward answering the following general questions:

#### Personality factors

1. What type of personality did the patient have before onset of involutional psychosis, with

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<sup>2</sup> Albert Deutsch, The Mentally Ill in America, Doubleday, Doran and Company, 1937, p. 493.

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1. What type of personality did the patient have before onset of involutional psychosis, with
- Personality factors



emphasis on:

- a. tendency toward worrying or depression
- b. emotional instability.

#### Physical factors

2. What was the relationship of physical condition to involutional psychosis prior to admission to the Boston State Hospital?

#### Social factors

3. What types of experiences has the patient had to face prior to admission to the hospital such as:

- a. children leaving home for various reasons
- b. death of close relatives
- c. breaking up of home - loss of many protecting factors - living alone.

4. In what way do the following social factors influence involutional psychosis:

- a. family and marital maladjustments
- b. economic maladjustments.

#### Scope of the Study

The study is based on a group of cases that were admitted to the Boston State Hospital during a two year period - January 1, 1946 to January 1, 1948, and who were diagnosed as having involutional psychosis. The patients' ages range from about thirty-eight to sixty-six years.

#### Method of Approach

The method of procedure used in arriving at a solution to the problem was to make a study of the case records of a

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- b. death of close relatives
- c. breaking up of home - loss of many people
- d. social factors - living alone.

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#### Scope of the Study

The study is based on a group of cases that were admitted to the Boston State Hospital during a two year period - January 1, 1945 to January 1, 1947, and who were diagnosed as having involuntal psychosis. The patients' ages range from about thirty-eight to sixty-six years.

#### Method of Approach

The method of procedure used in arriving at a solution to the problem was to make a study of the case records of a



group of twenty-one patients with involutional psychosis who were admitted to the Boston State Hospital during the years January 1, 1946 to January 1, 1948.

It is a random sample in that it includes all the cases of involutional psychosis which were in the file from A - Z on the days records were selected.

The case material for this thesis was gathered from the medical and social service records at the Boston State Hospital.

In making the study of the twenty-one cases, the information for each case was recorded by the use of a schedule as shown in Appendix B.

It is not the intention of the writer to infer that her conclusions are drawn from a statistical analysis, as the number of cases presented is too small; rather she is testing a certain number of cases against hypotheses described in the literature.

Involution, or the climacteric, like puberty, is a perfectly normal and universal phase of life.

"Menopause" is the most common term applied to the phenomena of sexual involution. Obviously the word "menopause" is inapplicable to men, who cannot cease having senses. The term "climacteric", however, is fairly appropriate to

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## Chapter II

### THE PROBLEM OF THE CLIMACTERIC

What is it we fear about the "second forty years"?

Though this fear is well nigh universal, different individuals give varying reasons for their dread. Some abhor the idea of losing the attractiveness of their youth; others deeply resent the loss of physical vigor. Not infrequently these fears are associated with a distorted outlook about the anticipated decline of sexual vigor and enthusiasm. Other people first become anxious over their economic security when past the meridian. Many are vaguely conscious that with true senility there will occur a decline in social prestige and respect.

The reproductive period of human life covers approximately one-third of our optimum life expectancy. Fertility begins late and ends early. From puberty to sexual involution is normally a span of about thirty to thirty-five years. Sexual involution, or the climacteric, like puberty, is a perfectly<sup>3</sup> normal and universal phase of life.

"Menopause" is the most common term applied to the phenomenon of sexual involution. Obviously the word "menopause" is inapplicable to men, who cannot cease having menses. The term "climacteric", however, is fairly appropriate to

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<sup>3</sup> Edward J. Stieglitz, The Second Forty Years, J.B. Lippincott Company, 1946, p. 193.

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both sexes. The popular phrase, "the change of life", is usefully descriptive, but puts too much emphasis upon one of the many changes which constitute living and aging.

### The Female Climacteric

Generally speaking, woman's capacity for reproduction lasts as long as menstruation is regular. With the cessation of this function she ends her service to the species. The end of menstruation indicates that ovulation has ceased and that the whole glandular apparatus has interrupted or decreased its activity. The genital organs become atrophied and the rest of the body gradually shows symptoms of aging. The menopause is a critical period, and whatever influence the changes in hormonal activity may exert upon the whole psychosomatic picture, there is no doubt that the mastering of the psychological reactions to the organic decline is one of the most difficult tasks of woman's life.

Usually the climacterium has a preliminary phase, marked by certain phenomena that presage the end: menstruation becomes irregular, appears at longer or shorter intervals, and the amount of discharge increases or decreases. Vasomotor disturbances appear, with the characteristic "hot flushes", sensations of dizziness, sweatings; these are often accompanied by headaches, neuralgias, etc. As a rule, all the subjective physical complaints of this period of life are

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considered as "climacterical" and are explained on the basis of the modified glandular function. The same is true of the psychologic symptoms that appear at this time - insomnia, anxiety states, excitability, and depressions. The whole course of the climacterium is undoubtedly determined by the fact that with the cessation of ovarian activity the remainder of the endocrine system is deranged in its functioning. The individual manifestations of the climacterium, however, greatly depend upon the given woman's personality.

The climacterium is under the sign of a self-conscious fixation that is difficult to overcome. In this phase woman loses all she received during puberty. With the onset of the genital retrogressive processes, the beauty-creating activity of the inner glandular secretions declines, and the secondary sex characteristics are affected by the gradual loss of femininity. The biological process, actual or imminent, is perceived internally before the organic changes. While still organically capable of conception, woman feels the threatened devaluation of the genitals as organs of reproduction. This inner signal, combined with her perception of the first signs of old age, heightens the woman's interest in her own person. A struggle for the preservation of femininity, now in process of disappearance, sets in. This struggle fills out the pre-climacterical life period before the genital function has really stopped.

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It is difficult to define exactly the age of the pre-climacterium. Broadly speaking, the age of the psychological preclimacterium is between forty and fifty, regardless of whether ovulation takes place or not. And there also are many preclimacterical elements during the phase when the physiological reduction of functions is already in full swing.

The preclimacterical thrust of activity and the return to an old psychic attitude is set in motion by several motives. Inner and outer signals play a part in this process. Among the outer ones, there is the imminent or already begun emancipation of the children from their mother, the cutting of the psychic umbilical cord on the part of the children. With the approach of the climacterium, new motherhood is impossible, and the frustrated activity is directed toward other goals.

The more unconscious motive for the new activity is the perception of the imminent disappointment and mortification. Here the activity has the effect of a defense mechanism. At the moment when expulsion of ova from the ovary ceases, all the organic processes devoted to the service of the species stop. Woman has ended her existence as bearer of a future life, and has reached her natural end - her partial death - as  
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4 Helene Deutsch, Psychology of Women, Grune and Stratton, Incorporated, 1945, Volume II, pp. 456-459.

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<sup>4</sup> Helene Deutsch, *Psychology of Women*, Grune and Stratton, Incorporated, 1955, Volume II, pp. 456-459.



stand that if a woman, during this period of life, can direct her drives toward other goals such as interest in community affairs, taking up an old hobby, returning to her former profession, she may manage to weather the experience of the menopause without too much damage to her personality.

### The Male Climacteric

It is only relatively recently that the climacteric phenomena have been identified in connection with the aging of men. For many years it was assumed that there was no such thing as a masculine climacteric because there was no specific demarcation of involution, such as the menopause in women. It is now more or less accepted by physicians in general, and endocrinologists in particular, that a male climacteric does occur and that it is quite similar to that of women. The only definite evidence of the masculine climacteric is the gradual diminution of sexual potency and libido. There is a greater variation in the chronological age at which this occurs than in women, but the average is distinctly later. The masculine climacteric usually falls within the decade from fifty-five to sixty-five years. Well authenticated exceptions are not uncommon. Potency and fertility have been demonstrated well into the ninth decade. Men do not all age alike, and senescence is often grossly asymmetric.

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may or may not result from the diminishing supply of male sex hormones. Common are complaints of fatigability and of mental and physical lassitude associated with insomnia rather than drowsiness. These symptoms may be the result of the generalized changes of senescence. As in the feminine climacteric, we must be extremely cautious not to interpret physical and emotional complaints as being solely due to the sex changes. Emotional changes are usually very mild, but they may be transiently incapacitating. A sense of apprehension, not pertaining to any specific threat, but vague and generalized, is common. There is often a tendency toward indecisiveness, a feeling of insecurity and uncertainty. If extreme, these emotional changes lead to depression.<sup>5</sup>

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<sup>5</sup> Stieglitz, op.cit., p. 196.

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## Chapter III

## INVOLUTIONAL PSYCHOSIS

In order that the reader may have a better understanding of the case material to be presented, the first part of this chapter will be devoted to a discussion of the meaning and symptoms of involutional psychosis. The remaining part of the chapter will be devoted to a discussion of various personality and social factors influencing the onset of involutional psychosis.

## Definition of Involutional Psychosis

According to the official American classification, involutional psychosis includes depressions of middle and later life characterized chiefly by agitation, uneasiness, sleeplessness and often self-condemnatory trends, but without organic intellectual defects. If these symptoms appear in a person who has ever in his life had a previous attack of excitement or depression, however, his illness is not to be classed as involutional psychosis, but as manic-depressive psychosis.

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6 J. McVicker Hunt, Personality and Behavior Disorders, The Ronald Press Company, 1944, p. 883.

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G. J. McVicker Hunt, Personality and Behavior Disorders, The Ronald Press Company, 1944, p. 283.



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Henderson and Gillespie consider involutional psychosis as a fairly common definite illness whose essential features are anxiety, unreality feelings, hypochondriacal or nihilistic delusions, and depression without retardation, occurring in women between forty and fifty-five, and in men between fifty and sixty-five years of age. They acknowledge that the same syndrome may occur in the twenties and thirties in women and before the fifth decade in men; and they go even further than the American classification in excluding all persons who have had any previous psychosis whatever, even though they may have all these symptoms and also be within the involutional period.

8

Hoch and MacCurdy consider the only genuine involutional psychoses as those showing fears of impending death, delusions of poverty and bodily disease, often with vivid hallucinations and great agitation and restlessness, but otherwise without intellectual impairment.

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Strecker and Ebaugh include the depressions of middle life and later years which have a prolonged course and are

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7 D.K. Henderson and R.D. Gillespie, A Textbook of Psychiatry, Oxford University Press, 1947, p. 265.

8 August Hoch and John T. MacCurdy, "Prognosis of Involutional Melancholia", American Journal of Psychiatry, Vol. 1, January, 1922, pp. 443-475.

9 Edward A. Strecker and Franklin G. Ebaugh, Clinical Psychiatry, P. Blakiston's Son and Company, 1935, p. 331.

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8 August Hoch and John T. MacGurby, "Prognosis of Involutional Melancholia", American Journal of Psychiatry, Vol. 1, January, 1932, pp. 443-448.

9 Edward A. Streckner and Franklin G. Ebaugh, Clinical Psychiatry, F. H. Blakiston's Son and Company, 1935, p. 331.



expressed clinically as a syndrome consisting of worry, insomnia, uneasiness, ideas of unreality and somatic delusions.

a. Melancholia

Depression without organic intellectual defect with agitation, uneasiness, insomnia, often with self-condemnatory trends. If there is evidence of previous attacks of depression or excitement, should be classed with manic-depressive group.

b. Paranoid type

Transitory or prolonged paranoid trends during the involutional period without any previous indication of paranoid reactions.

c. Other types (to be classified)

Other types of psychotic reactions during involutional period and from which organic brain disease can be excluded.

Thus have been seen several well-known ways of viewing the involutional psychosis; however, one is not restricted to selecting one and only one of these approaches, for indeed by far the most common concept of the involutional psychosis is a consolidation and synthesis of these tenets.

It is worthy to note at this point that this disorder occurs three times as frequently in the female as it does in the male.

### Mental Symptoms in Involutional Psychosis

The outstanding feature in this illness is the anxious depression, which has often been preceded by a stage during which the patient has complained of tiredness, of feelings of

expressed clinically as a syndrome consisting of worry, insomnia, uneasiness, ideas of unreality and somatic delusions.

a. Melancholia  
Depression without organic intellectual defect with agitation, uneasiness, insomnia, often with self-condemnatory trends. If there is evidence of previous attacks of depression or excitement, should be classed with manic-depressive group.

b. Paranoid type  
Transitory or prolonged paranoid trends during the involutional period without any previous indication of paranoid reactions.

c. Other types (to be classified)  
Other types of psychotic reactions during involutional period and from which organic brain disease can be excluded.

Thus have been seen several well-known ways of viewing the involutional psychosis; however, one is not restricted to selecting one and only one of these approaches, for indeed by far the most common concept of the involutional psychosis is a consolidation and synthesis of these centers.

It is worthy to note at this point that this disorder occurs three times as frequently in the female as it does in the male.

#### Mental Symptoms in Involutional Psychosis

The outstanding feature in this illness is the anxious depression, which has often been preceded by a stage during which the patient has complained of tiredness, of feelings of



inadequacy, of being easily fatigued, and of sleeplessness. These patients also have physical symptoms, such as feelings of pressure in the head, and the attitude of such patients is one of great misery; they feel frightened, are restless, wring their hands, moan and groan, tend to rake over their past, the slightest faults becoming the most terrible crimes. They feel that there is no hope for them, and fear that they are to be thrown out, that they will be taken to prison, and that they will be tried and put to death. Such patients in their misery will often attempt to mutilate themselves, and the danger of suicide is great. In addition, they are very resistive to care and treatment, refusing food because they feel they are not entitled to it, or because they are suspicious lest it be poisoned; and besides blaming themselves, they hold themselves responsible for the condition of the others with whom they are associated.

There is as a rule very little clouding of consciousness; they are correctly oriented, the memory is good, and the individual realizes to a certain extent that he is ill.

In most acute types of disorder, hallucinations of a terrifying nature may occur, and a certain amount of dis-  
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10 Henderson and Gillespie, op.cit., p. 266.

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There is as a rule very little clouding of consciousness; they are correctly oriented, the memory is good, and the individual realizes to a certain extent that he is ill. In most acute types of disorder, hallucinations of a terrifying nature may occur, and a certain amount of disorientation is present.



## Social Factors in Involutional Psychosis

Social factors will act upon persons with a differing effect because of variations in constitutional make-up, content of emotional life, diversity of reactions to the totality of life experiences, and character of basic personality structure.

It is the major concern of the writer to present those relevant social factors in our culture which appear to play some crucial role in the development of psycho-pathological conditions in later life.

The human body normally begins to slow down long before it shows signs of wearing out. As the average person moves into the forties and fifties he undergoes a physical decline in motor performance, perception, learning, sensory acuity, muscular and secretory responses and neural coordinations. There tends to be a muscular and bone atrophy which contributes to the characteristic appearance and stature of those who are aging. The glands undergo involutional emaciation. To all these changes must be added the major and minor bodily changes which everyone picks up through accidents, disease, and repair processes as he runs his age course.

The biological factors that seem to cause most difficulty in adjustment for involutional men patients are: the general reduction in skill, strength and endurance and the lessening of sexual prowess. Of great importance in both men and women



## Social Factors in Involuntary Psychosis

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The biological factors that seem to cause most difficulty in adjustment for involutional men patients are: the general reduction in skill, strength and endurance and the lessening of sexual prowess. Of great importance in both men and women



are also their reactions to any reductions in drives and satisfactions that may be harmless to themselves but suggest to them a threat of illness, invalidism, and death, suspicions of neoplasm, deforming and disabling changes, and any serious impairment of hearing or vision. Although the reduction in strength and endurance is usually very gradual, the realization of it may come quite suddenly as the result of illness, injury, fatigue over a long period of time, or after some unexpected failure in competition with a younger person. Inability to adapt to these changes of decrease in vigor and endurance usually take one of two directions. The patients may give up too easily and try to justify this by complaining of tiredness, weakness, nervousness or incapacity; or they may refuse to accept the change and try to convince others that they are just as capable as they have ever been. This protest usually takes the form of mere rationalization with a continuous insistence that they, as individuals, are still competent. During this phase of over-compensation the patients tend to become anxious and may resort to alcohol for support. When they finally give up the struggle of protesting, the patients begin to complain of headaches, getting old, of many physical ailments although they may be in good general health. To some men, also, the loss of a youthful appearance raises problems touching upon their prestige and economic security.

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In women especially the principal emphasis is more on the retention of youthful appearance and fertility. For with these assets they may be able to hold the affection and respect of their friends and relatives. So the fading of these qualities is a serious personal threat. If their attempts to cover up the signs of aging by cosmetics and other devices fail, they are apt to begin to complain of fatigue and bodily disorders.

Reactions to a declining sex life vary; some individuals try to compensate by stepping up the level of sexual behavior and indulging in sex adventures, to gain reassurance that they are still sexually competent. Such active protests in middle and later life often leave them open to other hazards. And if, as usually happens, they fail to receive the return they expected, they suffer an increased sense of inadequacy.

Patients' inability to see or hear well robs them of much pleasure and diversion, and tends to isolate them from participation in social activities. This partial isolation, especially when daily conversation with others is hindered, encourages misunderstandings and misinterpretations, which, if not corrected, make the patients very suspicious and unhappy. They begin to lose the feeling of emotional support which they might get through social participation and they are left with feelings of anxiety, fear and discouragement.

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gree of relationship between physiological and psychological factors in aging. The process of aging is also a matter of change in social, economic and dominance status. These things can be as influential as involution in precipitating maladaptive reactions.

The changes which the average person in middle and later life seems to dread most of all are the loss of independence and the loss of significance.

11

Oscar Kaplan and Harold E. Jones state:

"It is quite inevitable that sooner or later one generation shall be superseded or displaced by the next in the active control and direction of affairs. For the large majority of older persons, this carries with it the practical certainty of drastically reduced circumstances, and at least a threat of complete social and economic dependence upon others which is feared more than death itself. When such a prospect looms on the horizon of habitually rather insecure persons it may initiate exaggerated reactions to anxiety, tension, fatigue and dejection."

A particularly serious consequence of dependence is that of having to leave one's own home and having to live with other people. Because of reduced circumstances and perhaps the loss of the marital partner, the aging person is faced with the necessity of stepping out of the established pattern of his own life and taking up an insecure position by living with someone else and not having a genuine part in the

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new surroundings.

Older people have usually set their own patterns of living and have come to depend on their familiar surroundings for the routines of their own daily living. To have to leave their own homes, and neighborhood and friends is a threat to them. For many of them it is impossible to form new attachments and to develop a new routine of living under the altered conditions.

The immediate reaction to such uprooting or even an anticipation of it is one of anxiety. In such a setting a reactive neurotic depression may appear, often with elements of aversion that are easy to understand but hard to handle. Some of these people may take refuge in fantasy and reminiscence, and they begin to worry about their body and complain of bodily functions.

Besides the loss of familiar objects, persons and routines upon which they are greatly dependent, there is the loss of social significance which comes in later life.

As the average person passes his prime, he finds the younger generation, in the home and out of it, gradually superseding him; he finds himself giving up his positions and being edged away from the center of the floor to the sidelines. He is expected to accept this change without protest or ill-humor. He finds himself called upon to approve and admire the persons whom he remembers in the romper and diaper

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stage. Women no longer hear their own attractiveness discussed but must listen to compliments given to younger women. Their sons and daughters begin to wield authority rather than yield to it. For many aging people it is not easy to have to sit on the sidelines and give up control of their children, domestic arrangements, and losing their accustomed place in home affairs, the neighborhood, and their circle of relatives and friends.

Retirement from work or loss of a job has an important psychological effect on persons when it comes too early or too suddenly. Individuals who have been active all their lives and are suddenly thrown into inactivity find it difficult to adjust themselves as they are lost in endless spare time. They lose their external routine of habits and personal identity. It is this experience of not being wanted or of being unable to work, of being deprived of the incentive and the opportunity to carry on their accustomed work that brings on a feeling of restlessness, chronic fatigue, dejection and depression with great feelings of self-depreciation.

#### Personality Factors in Involutional Psychosis

Problems encountered at this stage of life often represent subjective reactions to the involutional era. Emphasis should not be centered upon the physical factors alone, for

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there are important personality and psychological factors that contribute to the picture of the involutional period. It is definitely a period of psycho-physiological stress.

In a significant number of cases of involutional psychosis we find a certain general type of personality make-up and of habits of life. A review of the patient's previous personality and temperament often shows that he has been an inhibited type of individual with a tendency to be serious, chronically worrisome, intolerant, reticent, sensitive, frugal, even penurious, stubborn, of rigid moral code, lacking in humor, over-conscientious and given to self-punishment.

Often his interests have been narrow, his habits stereotyped, he has cared little for diversion, has avoided pleasure and has had but few close friends. Frequently he has been a loyal subordinate, meticulous as to detail, rather than an aggressive, confident leader. Many have been worrying, fidgety, fretful, apprehensive persons. Some have shown characteristics of a compulsive neurotic nature. The pre-psychotic personality seems to have been characterized by a deeply seated sense of insecurity.

The age at which the psychosis develops is one when adjustments to new situations and circumstances are no longer easily made. Perhaps life has not brought either the success or satisfaction that hope had cherished. At this period there is a more or less conscious recognition that early

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dreams and desires cannot now be fulfilled, that the zenith of life has been passed and that ambition and life's forces are waning. The fact that opportunity no longer exists for repairing old errors or achieving new successes creates a sense of frustration and increases the feeling of insecurity. In women loneliness or fear of a loss of physical attractiveness may be a contributing factor. The transition to another stage of life with its new and difficult problems, both psychological and biological is not easy. Regrets and a sense of failure contribute to the prevailing mood. Acquired compensations begin to fail. An ebbing potency in the male and the realization of the woman that her most highly prized biological possession, that of child bearing, perhaps long frustrated, is now a lost capacity, is for the patient more than the loss of one of the most fundamental of functions - it is a symbol that both the sources and ends of energy have failed. As the flush of maturity fades, thoughts of death are suggested and contribute to the anxiety so common in the disease. With the decrease of physical strength unconscious forces, old conflicts and complexes become relatively stronger and return to threaten and torment. Their menace to the ego is ceaseless and since the source of the danger is hidden and within, any escape from it is impossible, with the result that the apprehension, tension and unrest of anxiety are intensified. In a certain number of cases retirement from

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business means the renunciation of long-cherished interests and a withdrawal of psychic energy. It is not surprising, therefore, that in the event of some disturbing experience, such as the breaking-up of the home, the loss of position, or the death of one upon whom dependence was felt, the psychosis with its pathological depression, apprehension, ideas of death and nihilistic and hypochondriacal delusions should be<sup>12</sup> precipitated.

From the foregoing discussion we have seen that the degree and mode of acceptance of involution, when it comes, will to a considerable extent depend on one's habitual premorbid attitude toward the body's competence and appearance. The skin and its appendages, which possess very high narcissistic value, and are also among the first systems to show the effects of aging. The great importance of this factor in the average woman's life, the important role it plays in her gaining and holding attention and prestige, has already been mentioned.

Cameron states:

"In later maturity men as well as women may become keenly sensitive over their progressive loss of attractiveness, and both may begin to look for signs that others care less of them or dislike them on this account. This can strike at the roots of personal security in those many individuals who have always depended upon strong emotional attachments and signs of acceptance by others. To persons who have habitually demanded of themselves perfect health and endurance, the signs of in-

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<sup>12</sup> Arthur P. Noyes, Modern Clinical Psychiatry, W.B. Saunders Company, 1939, p. 303.

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volution may seem very threatening and may succeed in arousing anxieties, compulsive rituals, or hypochondriacal preoccupation with health and disease. Personal reorientation toward biological involution usually involves a recognition and an understanding of the part played in one's economy by an over-evaluation of good looks, strength, endurance, and sexual attractiveness, and the ability progressively to modify one's attitude toward one's demands upon his organism as it grows progressively less attractive.<sup>13</sup>

Following questions:

1. What type of personality did the patients have

before onset of involutional psychosis, with

emphasis on:

- a. tendency toward worry or depression
- b. emotional instability

2. What was the relationship of physical condition

to involutional psychosis prior to admission to

the Boston State Hospital?

3. What types of experiences has the patient had to

face prior to admission to the hospital such as:

- a. children leaving home for various reasons
- b. death of close relatives
- c. breaking up of home - loss of many protecting factors - living alone

4. In what way do the following social factors in-

fluence involutional psychosis:

- a. family and marital readjustments
- b. economic readjustments

The eleven cases with the most complete information were

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<sup>13</sup> Norman Cameron, "Neuroses of Later Maturity", Mental Disorders in Later Life, Stanford University Press, 1945, p. 165.

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## Chapter IV

### STUDY OF THE CASES

It is the purpose of the writer, in the study of the cases, to look at them with a view toward answering the following questions:

1. What type of personality did the patient have before onset of involutional psychosis, with emphasis on:
  - a. tendency toward worrying or depression
  - b. emotional instability
2. What was the relationship of physical condition to involutional psychosis prior to admission to the Boston State Hospital?
3. What types of experiences has the patient had to face prior to admission to the hospital such as:
  - a. children leaving home for various reasons
  - b. death of close relatives
  - c. breaking up of home - loss of many protecting factors - living alone
4. In what way do the following social factors influence involutional psychosis:
  - a. family and marital maladjustments
  - b. economic maladjustments

The eleven cases with the most complete information were selected for discussion from a group of patients admitted to the Boston State Hospital over a two year period - January 1, 1946 to January 1, 1948. The group consisted of twenty

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It is the purpose of the writer, in the study of the cases, to look at them with a view toward answering the following questions:

1. What type of personality did the patient have before onset of involuntal psychosis, with emphasis on:
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  - b. emotional instability
2. What was the relationship of physical condition to involuntal psychosis prior to admission to the Boston State Hospital?
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  - b. death of close relatives
  - c. breaking up of home - loss of many protecting factors - living alone
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The eleven cases with the most complete information were selected for discussion from a group of patients admitted to the Boston State Hospital over a two year period - January 1, 1946 to January 1, 1948. The group consisted of twenty



patients whose ages ranged from thirty-eight to sixty-six years, and whose diagnosis was involutional psychosis.

See Table I for classification of patients by diagnosis; Table II, page twenty-seven, for a classification according to the country of their birth; Table III, page twenty-eight, for classification according to their marital status; and Table IV, page twenty-nine, for classification according to their formal education.

These tables are included in an attempt to describe some of the background information of the twenty cases selected for this thesis.

Table I

CLASSIFIED DIAGNOSIS OF INVOLUTIONAL PATIENTS UNDER STUDY

Classification	No. of Patients
Melancholia	8
Paranoid	3
Other types	9
TOTAL	20

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Table II

## BIRTH PLACES OF THE PATIENTS UNDER STUDY

Places of Birth	No. of Patients
United States	12
Sweden	1
Ireland	3
Italy	2
Canada	1
Poland	1
TOTAL	20





Table IV  
Table III

MARITAL STATUS OF THE PATIENTS UNDER STUDY

THIRTY-SEVEN YEARS OF AGE AND WITH  
INVOLUTIONAL PSYCHOSIS

Marital Status	No. of Patients
Single	5
Deserted School	1
Legal Separation	1
Widowed	3
Married	10
Unknown	2
TOTAL	20

Table III

MARITAL STATUS OF THE PATIENTS UNDER STUDY

No. of Patients	Marital Status
3	Single
1	Deserted
1	Legal Separation
3	Widowed
10	Married
20	TOTAL



Table IV

THE FORMAL EDUCATION OF THE 20 PATIENTS OVER  
THIRTY-SEVEN YEARS OF AGE AND WITH  
INVOLUTIONAL PSYCHOSIS

Education	No. of Patients
Grammar School	13
Night High School	1
High School	3
Illiterate	1
Unknown	2
TOTAL	20

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### Personality of Patients Before Onset of Illness

In the following three cases, tendency toward worrying or depression, and emotional instability play an important role in the patients' lives. These cases are given in an attempt to answer the question, "What type of personality did the patient have before onset of involutional psychosis, with emphasis on: tendency toward worrying or depression, emotional instability?"

#### Case I:

Mrs. L., a housewife, is sixty-two years old and was admitted to the Boston State Hospital on August 7, 1946. She was diagnosed as having Involutional Psychosis, Other types. The patient was brought from home by her son and daughter. The physician's certificate stated that she had no idea where she was or how long she had been there. Upon admission she behaved in an excited manner, was quite agitated, fearful, and appeared to be hallucinated. She appeared, on short examination, to have a toxic hallucinosis, but no history of drug injection could be obtained from her. Her daughter said she had taken luminal in considerable amounts for two months and had taken many other medications at the same time. Physical examination revealed she was well developed, well nourished, and showed a red tongue and sore lips. Information from temporary care papers stated patient had been markedly depressed for many weeks, had had spells of shaking of arms, seemed confused at times, and was uncooperative.

Mrs. L., was born in Massachusetts, in 1884. She was one of six children, having three brothers and two sisters. She always leaned toward the youngest brother. The patient's parents were divorced when patient was five years old. When her parents were divorced, the patient's



# Personality of Patients Before Onset of Illness

In the following three cases, tendency toward worrying or depression, and emotional instability play an important role in the patients' lives. These cases are given in an attempt to answer the question, "What type of personality did the patient have before onset of involuntarial psychosis, with emphasis on: tendency toward worrying or depression, emotional instability?"

## Case I:

Mrs. L., a housewife, is sixty-two years old and was admitted to the Boston State Hospital on August 7, 1946. She was diagnosed as having Involutional Psychosis, Other types. The patient was brought from home by her son and daughter. The physician's certificate stated that she had no idea where she was or how long she had been there. Upon admission she behaved in an excited manner, was quite agitated, restless, and appeared to be hallucinated. She appeared on short examination, to have a toxic hallucinosis, but no history of drug ingestion could be obtained from her. Her daughter said she had taken insulin in considerable amounts for two months and had taken many other medications at the same time. Physical examination revealed she was well developed, well nourished, and showed a red tongue and sore lips. Information from temporary care papers stated patient had been markedly depressed for many weeks, had had spells of shaking of arms, seemed confused at times, and was uncooperative.

Mrs. L. was born in Massachusetts, in 1884. She was one of six children, having three brothers and two sisters. She always feared toward the youngest brother. The patient's parents were divorced when patient was five years old. When her parents were divorced, the patient's



mother had a comfortable home. The father moved to Wyoming and remarried. He was not heard of until after his death revealed a will. It was said the patient's childhood was like a nightmare, and very unhappy. Patient's mother died at age eighty-two.

The patient had very little schooling. She was not particularly religious. Her one ambition was to study music. Patient was married twice and there were three children of which two were girls and one a boy. Patient divorced her first husband when the children were very young. She worked as a domestic, and always struggled because the children's father did not always pay for their support. At one time patient had to accept charity because her daughter did not care to work. Patient married second husband, who was the informant in this case, after they had lived in the same house for seven years. Her husband was not making enough to support her, and patient agreed to work as a practical nurse, because as she expressed it she "couldn't sleep so she might as well help someone who could". Patient was treated for insomnia at New England Hospital. She was always complaining of her inability to sleep.

Patient's children were a constant source of worry to her. One daughter was homosexual, and alcoholic. Another daughter married very young, was divorced, later married a man out of her faith. The patient was heartbroken when the daughter ran about town with other men while her husband was in the service. Patient often spoke of how respectable her husband's children were, and wondered why her children could not have given her a little peace. Patient always got along with her family and friends, but when disturbed her temper was unbearable. She often threw things, or struck her grown children. Patient's love for her youngest brother turned to hate when a sum of money willed to her was used deceitfully by him while he was administrator. Patient settled the case out of court, but was somewhat depressed later because she had to resort to legal tactics with a brother she trusted.

During the patient's later life she enjoyed automobile rides, movies, and opera music. She



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During the patient's later life she enjoyed automobile rides, movies, and opera music. She



smoked cigarettes occasionally, took sleeping pills when prescribed, did not indulge in alcohol.

Patient has a medical history of a hysterectomy performed twelve years ago.

This case is a picture of a person reaching her later years and having continual discouraging family experiences against which she had always struggled. The fact that life had not brought all that was desired became more and more evident to her, as well as the certainty that strength was waning and that whatever life had not already brought could never be attained. The record showed that her children had always caused her considerable worry. She had always been emotionally unstable, demonstrating an unbearable temper, and a long history of insomnia. The inability to live up to high standards lead to guilt and aversion reactions; and projections in the form of hallucinations occurred in the setting of insecurity, guilt, anxiety and depression.

It must be assumed that general bodily disorders accompanied the worry, tension and tribulations. It is generally true that worries and continuous tension have a weakening effect on the body. As physical energy declined with the involutional changes the anxiety, depression and fear could no longer be withstood and a psychosis developed.

#### Case II:

Mr. A., age forty-five, was admitted to the

smoked cigarettes occasionally, took sleeping pills when prescribed, did not indulge in alcohol.

Patient has a medical history of a hysterectomy performed twelve years ago.

This case is a picture of a person possessing her later years and having continual discouraging family experiences against which she had always struggled. The fact that life had not brought all that was desired became more and more evident to her, as well as the certainty that strength was waning and that whatever life had not already brought could never be attained. The record showed that her children had always caused her considerable worry. She had always been emotionally unstable, demonstrating an unstable temper, and a long history of insomnia. The inability to live up to high standards led to guilt and aversion reactions; and projections in the form of hallucinations occurred in the setting of insecurity, guilt, anxiety and depression.

It must be assumed that general bodily disorders accompanied the worry, tension and irritations. It is generally true that worries and continuous tension have a weakening effect on the body. As physical energy declined with the involutional changes the anxiety, depression and fear could no longer be withstood and a psychosis developed.

## Case II:

Mr. A., age forty-five, was admitted to the



Boston State Hospital on October 10, 1946. His case was diagnosed as Involutional Psychosis, Other types. The patient was brought from the Boston Psychopathic Hospital by his wife. Upon admission he had suicidal ideas, slight pressure of speech, was not hallucinated or deluded, was quiet, cooperative and oriented. It was also noted that the patient dated the onset of his difficulty to an episode of masturbation a month before admission, and he is impotent. The patient wanted to commit suicide but thought it would be a sin to do so. Thought he had lost his mind and talked about it all day. He wouldn't eat as he said it was wasting food. He had been confused, could not do his work and was hearing voices saying, "kill yourself".

Mr. A was the youngest of eight children born to parents in Maine. Patient and an older brother are the only two children living. His mother and father were of Irish descent. His parents were very strict and never permitted the children to mix with other children. They were always kept by themselves, and the patient always played only with his brother. The patient's father died at the age of eighty-two of a strangulated hernia; his mother died of Bright's Disease at age forty-four.

The patient went to the sixth grade of school, and stopped at age sixteen because he didn't want to go any further. In later life he rarely if ever went to a movie, never bothered with friends, usually sat listening to the radio while smoking his pipe.

The patient was a very sickly child throughout his childhood. He had pneumonia with convulsions and many other illnesses. He has always been nervous.

The patient's wife was his first and only girlfriend. They have known each other for twenty-four years. During World War I the patient worked in the Navy Yard. When he met his wife he was a shipping clerk with a candy company. When that company moved he went to work for the American Railway Express Company where he worked his way up to foreman. He worked there until he



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became ill. He had worked steadily and hard to make a good home for his wife and eight children, all of whom are living in the home. He never displayed any favoritism among his children of whom six are girls and two are boys.

The patient has always been very quiet; he feared trouble and arguments. He became easily upset when confronted by hostility. He never argued with his wife or struck the children for fear of hurting them. His wife "bossed" the family; neither patient nor his wife has been overly affectionate. He never manifested any real love for his wife. If the wife became ill the patient would almost become ill through worry. The patient has never been jealous of his wife, he was always sure of her. He has never shown any temper outbursts, suspicions or mood swings. He has always been immaculate and clean; he was afraid of germs. The patient's wife had the responsibility of handling the family and its affairs until about twelve years ago. Since then the patient worried moderately about family affairs.

The patient's illness began in August, 1946 with headaches, and he later began to shake all over. A private physician gave him sedatives with temporary good effect. In August he felt he lost his mind and could not think any more. Voices began talking to him in June, 1946 and stopped in August, 1946. One night in June, 1946 he was sitting alone at home smoking his pipe when he suddenly, without any apparent conscious effort on his part, masturbated. He felt badly about it and couldn't understand why he had done it. He thought it was a mortal sin. Since then he has felt very guilty. The patient stated, "I got all nervous and excited because my kid was coming home from the South West Pacific". Voices told him to kill his family and commit suicide because "he was doomed".

The first obvious changes were noted in August when the patient complained of his "brain being burned out". He gradually began to stay home from work. He would pace up and down the room saying he had lost his wife, children, his work, and his mind. He didn't seem able to sit. He was apparently agitated. He would awaken at



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three o'clock in the morning unable to sleep; and refused to eat until coaxed. He nibbled at food in the icebox, and rarely sat down to a meal.

The life long history and personality picture of this case is that of a very meek type of person, self-effacing, reserved, shy, easily and always dominated by his mother and then his wife, and who has succeeded in getting along with his fellow men by repressing entirely all aggressive desires. Repression of this kind has been present all his life and extends throughout his personality including his sexual feelings as well. He approached the climacteric and with it hostile wishes began to come to the surface. Voices told him to murder his children, and he experienced anxiety feelings about his son who recently returned from overseas. He was preoccupied with sex which became manifest in the masturbatory episode, and he found it easy and convenient to explain away all his difficulties on that basis. His life became very unpleasant with its emerging conflicts and he became depressed.

### Case III:

Mr. J., age fifty-five, was admitted to the Boston State Hospital on January 4, 1946. He was diagnosed as Involutional Psychosis, Other types. The patient was brought from home by his wife and son.

Two days before admission the patient refused to answer questions asked by his wife; and he had been eating less and less. The patient's wife called a private physician who

Three o'clock in the morning unable to sleep; and refused to eat until noon. He nibbled at food in the icebox, and rarely sat down to a meal.

The life long history and personality picture of this case is that of a very weak type of person, self-effacing, reserved, shy, easily and always dominated by his mother and then his wife, and who has succeeded in getting along with his fellow men by repressing entirely all aggressive desires. Repression of this kind has been present all his life and extends throughout his personality including his sexual feelings as well. He approached the climacteric and with it his life wishes began to come to the surface. Voices told him to murder his children, and he experienced anxiety feelings about his son who recently returned from overseas. He was preoccupied with sex which became manifest in the masturbatory episode, and he found it easy and convenient to explain away all his difficulties on that basis. His life became very unpleasant with its emerging conflicts and he became depressed.

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Two days before admission the patient refused to answer questions asked by his wife; and he had been eating less and less. The patient's wife called a private physician who



advised that she take the patient to a mental hospital. The patient was neither homicidal, threatening, nor suicidal. For the preceding six months his memory seemed impaired, but he remembered his way around. Upon admission he was evasive and suspicious; had to be asked questions several times before he gave information. He said he worked in the Navy Yard but stopped because he became too "nervous". He had vague paranoid ideas but was reluctant to talk about them. When asked if he thought his family put something in his food he said, "sometimes I think so. I'm not sure". When asked about tearing up his last pay check, he said, "I did so because I couldn't get along with my wife".

The patient, a naturalized citizen, was born in Ireland. He came to the United States in 1910. He has one sister who lives in Chicago with whom he lost contact. Little is known about the patient's early life other than that he was educated in Ireland; the extent of his education is unknown. The patient's parents were born in Ireland. His father died of natural causes, his mother died of unknown causes.

The patient at age thirty married a woman three years older than himself. They had four sons. For the last sixteen years the patient worked as a machine operator at the Navy Yard. Previously he worked for six years as a grocery store clerk. He stopped work in July, 1945.

The patient was said to be of a quiet, introverted personality. He never started a conversation, but would keep one going if someone else started it. He never confided in anyone. After work he spent his time reading about current events, taking long walks, or listening to Irish records. He never complained about uncomfortable conditions. He had one queer trait, he never spoke to relatives when he met them on the street; however, he did talk to them at home.

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his mouth, which caused him considerable worry. His physician said it was a minor irritation and would clear up; he was also told he had hardening of the arteries. The sore cleared up, but the patient worried about it so much that he quit his job. Seven or eight days before admission the patient would not eat much because he imagined his family put dope in his food; he began to think the whole family was against him. He hid bonds around the house, and spent most of his time sitting idle in a chair and staring into space.

This case shows a picture of a man who is of a quiet, introverted personality. He had a tendency to worry - as was indicated by his preoccupation with a mouth sore. His emotional instability was manifested in his introverted behavior. He never started a conversation but would keep it going once it was started. When meeting relatives on the street he never spoke to them. Any hostility or anxiety which the patient felt was always repressed, and he never complained. Although no mention was made of marital discord, it was noted in the record that the patient said he tore up his pay check because he didn't get along with his wife. In tearing up his check and in quitting his job the patient displayed his hostility toward those around him. He always preferred to be by himself as was indicated by the time he spent reading, taking walks alone, and listening to records. His need to save or hoard was possibly a reaction to the threats of material insecurity in the aging period.

These characteristics proved sufficient support for the personality until the involutinal period when, with the add-



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ed physiological and psychological burdens which may attend the climacterium, they were no longer adequate and resort was had to the more extreme defensive and compensatory measures provided by the paranoid delusions, misinterpretations and distortions of reality.

### The Relationship of Physical Condition to Involutional Psychosis

Of the twenty cases studied, twelve of the patients had physical illness prior to the need for hospitalization in a mental institution. Eighteen of the patients studied had ailments of some type. In Table V, page thirty-nine, are listed the illnesses or ailments that occurred in the four men and sixteen women whose cases were studied.

It is the purpose of this section of the chapter to attempt to answer the question, "What was the relationship of the physical condition of the patients studied to involutional psychosis prior to admission to the Boston State Hospital?" The following three cases came within this classification.

#### Case IV:

Mrs. B., age thirty-eight, was admitted to the Boston State Hospital on March 27, 1946, and was diagnosed as having Involutional Psychosis, Melancholia.

The patient had been brought to the hospital from the Faulkner Hospital where her chief com-

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Table V

OCCURRENCES OF SICKNESSES AND AILMENTS IN THE STUDY OF  
FOUR MALE AND SIXTEEN FEMALE PATIENTS WITH INVOLUTIONAL  
PSYCHOSIS

Sickness or Ailment	Male	Female	Total
Appendicitis		1	1
Hardening of Arteries	1		1
Thyroidectomy		1	1
Hysterectomy		4	4
Retinal Sclerosis	1		1
Curvature of Spine		1	1
Toxemia due to Barbiturates		1	1
Coronary Thrombosis	1		1
Dehydration		5	5
Deafness		2	2
Fractured Hip		1	1
Carcinoma of Ovary		1	1
Gall Bladder		1	1
Vertigo		1	1
Headaches		2	2
Stomach	1		1
Rupture	1		1
Deformed Wrist		1	1
Hypertension		1	1

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Sickness or Ailment	Male	Female	Total
Hypercalcemia		1	1
Deformed Wrist		1	1
Rhinitis	1		1
Stomach	1		1
Headaches		2	2
Vertigo		1	1
Gall Bladder		1	1
Carcinoma of Ovary		1	1
Fractured Hip		1	1
Deafness		2	2
Dehydration		2	2
Coronary Thrombosis	1		1
Toxemia due to Barbiturates		1	1
Curvature of Spine		1	1
Retinal Sclerosis	1		1
Hysterectomy		4	4
Thyroidectomy		1	1
Hardening of Arteries	1		1
Appendicitis		1	1



plaint had been vertigo and moderate dehydration. On the day after admission to the Faulkner Hospital a lumbar puncture was done with ease and with complete cooperation of the patient. Within the next twenty-four hours she developed an acute psychotic state and was practically uncontrollable. This did not subside and the patient was sent to the Boston State Hospital, where upon admission she talked in a low monotonous voice, was obviously depressed and fearful. She stated that she was in a hospital where they tried to poison her and afterwards to burn her in an incinerator. She believed the people involved were people she had not seen for seventeen years, they were revengeful and tried to kill her.

The patient, a naturalized citizen, was born in Canada. She was the oldest of four children of which three were girls and one a boy who was the informant in this case. The patient's parents always lived in Canada. Her father, a fisherman, died of a fever sore on the leg when the patient was age ten; her mother is still living in Canada. The patient came to the United States in 1919 and married in Massachusetts in 1928.

The patient attended high school for three years, but before her marriage she did domestic work. Her husband is a carpenter. They have two children, a boy age sixteen and a girl age six. The patient is described as a very pleasant person, sociable and having many friends. When out of the house she was always full of life. At home, however, she worried a great deal about her children. She liked to read magazines and visit. The patient had been worried recently because her son wanted to join the Maritime Service; he has since entered it.

The patient has always been quite nervous, and following an appendectomy at age seventeen she had a hysterical spell when she laughed and cried. In 1936 an ovary and a fallopian tube were removed at Boston City Hospital; in 1938 she was treated at the Boston City Hospital for a peritonsillar abscess; in 1942 the patient had a hysterectomy at the New England Hospital after which she had hysterical spells. In 1944 the



plaint had been vertigo and moderate dizziness. On the day after admission to the Parkland Hospital a further episode was noted with loss and with complete cooperation of the patient. Within the next twenty-four hours she developed an acute psychotic state and was practically uncontrollable. This did not subside and the patient was sent to the Boston State Hospital, where upon admission she talked in a low monotone voice, was obviously depressed and fearful. She stated that she was in a hospital where they tried to poison her and afterwards to burn her in an incinerator. She believed the people involved were people she had not seen for seventeen years, they were revengeful and tried to kill her.

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patient was admitted to the Boston City Hospital because of a fractured hip. Following the admission to the Boston City Hospital at that time "her heart was weak and she went all to pieces".

The patient's husband was laid off at the Navy Yard in the middle of January, 1946 and was unable to get another job. This caused the patient considerable worry.

No change was noticed in the patient until February 7, 1946 when she went shopping with a friend and had a hysterical spell. The patient began crying, seemed very frightened, shivered and took hold of someone. Since that time she had frequent spells of being frightened and shivering. The friend took her to a private physician who gave the patient a nerve prescription which did not help. She was still ill and she was admitted to the Faulkner Hospital on March 24, 1946. Before admission there the patient had loss of appetite and had become so weak she could hardly lift a cup or go to the bathroom without holding on to something. She was never suicidal or assaultive.

This case is an example of physical deterioration lead-  
to mental breakdown. This patient was subject to many opera-  
tions most of which she responded to with hysteria. In  
Table V page thirty-nine we find that four of the patients  
had hysterectomies. This person was put in that category.  
It should be noted that the patient became so hysterical  
when shopping that she required medical attention. One may  
describe the hysterical symptoms as dramatic emotional reac-  
tions, especially fear and anxiety. The hysterectomy seemed  
to be one of several factors causing a psycho-pathological  
reaction. To the patient it meant the end of her use as a  
bearer of children, which to most women does not occur before



patient was admitted to the Boston City Hospital because of a fractured hip. Following the admission to the Boston City Hospital at that time "her heart was weak and she went all to pieces".

The patient's husband was laid off at the Navy Yard in the middle of January, 1948 and was unable to get another job. This caused the patient considerable worry.

No change was noticed in the patient until February 7, 1948 when she went shopping with a friend and had a hysterical spell. The patient began crying, seemed very frightened, shivered and took hold of someone. Since that time she had frequent spells of being frightened and shivering. The friend took her to a private physician who gave the patient a nerve prescription which did not help. She was still ill and she was admitted to the Fenner Hospital on March 24, 1948. Before admission there the patient had loss of appetite and had become so weak she could hardly lift a cup or go to the bathroom without holding on to something. She was never suicidal or homicidal.

This case is an example of physical deterioration leading to mental breakdown. This patient was subject to many operations most of which she responded to with hysteria. In Table V page thirty-nine we find that four of the patients had hysterectomies. This person was put in that category. It should be noted that the patient became so hysterical when shopping that she required medical attention. One may describe the hysterical symptoms as dramatic emotional reactions, especially fear and anxiety. The hysterectomy seemed to be one of several factors causing a psycho-pathological reaction. To the patient it meant the end of her use as a bearer of children, which to most women does not occur before



the menopause sets in. This case is an illustration of a woman who is insecure, and whose confidence in her physical and personality fitness was shaken. Her insecurity was accompanied by anxiety. Her resulting need for greater security led to her over-protective attitude toward her children, which was shown by her anxiety about her son's joining the Maritime Service. We should also note that when her husband lost his job she was greatly worried. Her fitness to deal with this socio-economic change was unsuccessful and led to another period of physical complaint, the vertigo, resulting in hysteria and subsequent admission to a mental hospital.

#### Case V:

Mr.R., age sixty-six, was admitted to the Boston State Hospital on June 7, 1947, and was diagnosed as having Involutional Psychosis, Melancholia. The patient was brought from home by his brother because of depression, refusal to eat, hallucinations and delusions of persecution. He had been unable to work since February, 1947 due to coronary heart disease. He had been hospitalized at Beth Israel Hospital for one month, from there he went to a convalescent home for a month. Since April he has been living alone in a room with a private family. The Cardiac Clinic at Beth Israel Hospital recommended his admission to the Boston State Hospital.

The patient was born in Michigan. He was the oldest and only son among three children. His mother, born in Boston, died at age thirty of childbirth; his father, born in Germany, remarried, and died at age seventy-five of a shock. The patient's step-mother died five years ago of unknown causes. The patient had three step-brothers and five step-sisters. The patient completed four grades of school, one of which he failed. He worked for his father in



the menopause sets in. This case is an illustration of a woman who is insecure, and whose confidence in her physical and personality fitness was shaken. Her insecurity was accompanied by anxiety. Her resulting need for greater security led to her over-protective attitude toward her children, which was shown by her anxiety about her son's joining the Maritime Service. We should also note that when her husband lost his job she was greatly worried. Her fitness to deal with this socio-economic change was unsuccessful and led to another period of physical complaint, the vertigo, resulting in hysteria and subsequent admission to a mental hospital.

#### Case V:

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The patient was born in Michigan. He was the eldest and only son among three children. His mother, born in Boston, died at age thirty of childbirth; his father, born in Germany, married, and died at age seventy-five of a shock. The patient's step-mother died five years ago of unknown causes. The patient had three step-brothers and five step-sisters. The patient completed four grades of school, one of which he failed. He worked for his father in



a clothing store, and has had many jobs since then, such as collector for a clothing store, and elevator operator. He liked sports but preferred to watch rather than play.

The patient never had much to do with girls. In 1920 he married a girl whom he had known for about a year. She died in 1931 when the patient was age fifty. They had no children. Since then the patient has had nothing to do with women. He was always economically independent and got along with other people. He was considered a good salesman and was neat and efficient in his work.

Mr. R. was a patient in Westboro State Hospital in 1932 following the death of his wife. He stayed there for sixteen months with a diagnosis of Involutional Psychosis, and was discharged as improved. At that time he was depressed and restless, much the same as when admitted to the Boston State Hospital this time.

The patient had been working as a night elevator operator in a hotel, and rooming with a private family. He was hospitalized in February and March of 1947 for a coronary condition. After his discharge from the Beth Israel Hospital arrangements were made by the Social Service there for nursing home care due to his inability to get adequate care at home. At the time of discharge from Beth Israel the patient accepted the fact that he could not work for several months until his condition improved. The patient seemed to adjust adequately to his limitations until two weeks before admission to the Boston State Hospital when he became depressed because of his inability to work, and the fact that he would soon have to move from his room because the family with which he was living needed the room for relatives. The patient began to refuse food, lost a great deal of weight, and began to barricade the door to his room to keep out "outsiders" whom he felt threatened him.

This case is a picture of a rather passive, dependent individual who has led a thwarted, inadequate existence. He was



a clothing store, and has had many jobs since then, such as collector for a clothing store, and elevator operator. He liked sports but preferred to watch rather than play.

The patient never had much to do with girls. In 1930 he married a girl whom he had known for about a year. She died in 1931 when the patient was age fifty. They had no children. Since then the patient has had nothing to do with women. He was always economically independent and got along with other people. He was considered a good salesman and was neat and efficient in his work.

Mr. R. was a patient in Westboro State Hospital in 1933 following the death of his wife. He stayed there for sixteen months with a diagnosis of Involutional Psychosis, and was discharged as improved. At that time he was depressed and restless, much the same as when admitted to the Boston State Hospital this time.

The patient had been working as a night elevator operator in a hotel, and rooming with a private family. He was hospitalized in February and March of 1947 for a company condition. After his discharge from the Beth Israel Hospital arrangements were made by the Social Service there for nursing home care due to his inability to get adequate care at home. At the time of discharge from Beth Israel the patient accepted the fact that he could not work for several months until his condition improved. The patient seemed to adjust adequately to his limitations until two weeks before admission to the Boston State Hospital when he became depressed because of his inability to work, and the fact that he would soon have to move from his room because the family with which he was living needed the room for relatives. The patient began to refuse food, lost a great deal of weight, and began to barricade the door to his room to keep out "outsiders" whom he felt threatened him.

This case is a picture of a rather passive, dependent individual who has led a thwarted, inadequate existence. He was



a person who never bothered much with other people but always managed to support himself economically. When he became ill and had to give up his job he seemingly adjusted for a while, but his secure position in what was apparently a comfortable living situation was threatened and caused him considerable anxiety. He had repressed his insecurity concerning his inability to work due to his cardiac condition, but his fears and anxiety were reactivated and resulted in depression, delusions and hallucinations. His hostility toward himself and his environment manifested itself in the projection of ideas that his life was threatened, to which he responded by locking his door. His sensitivity around his dependence on others due to his physical limitations was so great that any defenses he once had were broken down and the result was the psychosis.

#### Case VI:

Mrs. T., age forty-two, was admitted to the Boston State Hospital on April 23, 1946, and was diagnosed as having Involutional Psychosis, Melancholia. The patient was brought from home by her husband and sister. The physician's certificate stated that the patient said she was "all mixed up", she could not tell how long she had been at the hospital and admitted breaking a radio but could not say why she did it. Upon admission the patient was excited, noisy, not very cooperative. She has a pronounced hearing difficulty. According to the psychological report the patient's responses were generally coherent and relevant. She seemed apprehensive about her performance and was overly critical, interjecting self-deprecatory remarks such as, "I'm rather stupid, there are some things I'm just not able to grasp!" She



a person who never bothered much with other people but always managed to support himself economically. When he became ill and had to give up his job he seemingly adjusted for a while, but his secure position in what was apparently a comfortable living situation was threatened and caused him considerable anxiety. He had repressed his insecurity concerning his inability to work due to his cardiac condition, but his fears and anxiety were reactivated and resulted in depression, delusions and hallucinations. His hostility toward himself and his environment manifested itself in the projection of ideas that his life was threatened, to which he responded by locking his door. His sensitivity around his dependence on others due to his physical limitations was so great that any defense he once had were broken down and the result was the psychosis.

#### Case VI:

Mrs. T., age forty-two, was admitted to the Boston State Hospital on April 23, 1948, and was diagnosed as having Involuntary Psychosis, Melancholia. The patient was brought from home by her husband and sister. The physician's certificate stated that the patient said she was "all mixed up", she could not tell how long she had been at the hospital and admitted breaking a bottle over her head and hitting herself with it. Upon admission the patient was excited, noisy, not very cooperative. She has a pronounced hearing difficulty. According to the psychological report the patient's responses were generally coherent and relevant. She seemed apprehensive about her performance and was overly critical, interjecting self-deprecatory remarks such as, "I'm rather stupid, there are some things I'm just not able to grasp." She



responded well to praise; used a good deal of self-reference in her responses.

The patient was born in Massachusetts, April 20, 1904. She is the fourth oldest of six children. Her father, who died at age sixty-nine, worked for the City Sanitation Department; her mother age seventy-four, lives with the patient's siblings. The patient entered school at age six, and left school at age fourteen due to difficulties she experienced during menstruation which lasted ten days at a time. Her parents were very protective toward her. The patient worked in the Navy Yard as an office cleaner since 1943; previous to that she had not worked for ten years. She married her husband, a ship-fitter, in 1932, after having known him for twelve years. They have no children.

Mrs. T was an average person, always easy to get along with and made friends easily. She had no favorites among her siblings, and never looked for trouble. She is of a rather unstable temperament as evidence that she became rather depressed when a brother was killed in the last war. In 1927 the patient underwent a partial hysterectomy operation at the Boston City Hospital. In 1942 she started having difficulty with her hearing and had difficulty adjusting because of the partial deafness. In 1944 she underwent an operation at the Boston City Hospital for a complete hysterectomy. Since this last operation the patient's vagina closed to such an extent that sexual intercourse was difficult and painful. It was noted in the record that the patient said she was depressed after her operation in 1944, and was beginning to feel better when she received news of her brother's death, and became depressed all over again. Two months before admission to the Boston State Hospital the patient's sister lost a baby. The patient saw the baby's body and has been worrying about it ever since.

The patient's husband, who was the informant in this case, first noticed the patient's odd behavior on April 20, 1946, when the patient expressed the idea that the police were following them. The next day at dinner the patient acted queerly, as if she were going to cry. The next



responded well to praise; used a good deal of self-reference in her responses.

The patient was born in Massachusetts, April 30, 1904. She is the fourth oldest of six children. Her father, who died at age sixty-nine, worked for the City Sanitation Department; her mother age seventy-four, lives with the patient's siblings. The patient entered school at age six, and left school at age fourteen due to difficulties she experienced during menstruation which lasted ten days at a time. Her parents were very protective toward her. The patient worked in the Navy Yard as an office cleaner since 1943; previous to that she had not worked for ten years. She married her husband, a ship-fitter, in 1932, after having known him for twelve years. They have no children.

Mrs. T was an average person, always easy to get along with and made friends easily. She had no favorites among her siblings, and never looked for trouble. She is of a rather unstable temperament as evidenced that she became rather depressed when a brother was killed in the last war. In 1927 the patient underwent a partial hysterectomy operation at the Boston City Hospital. In 1942 she started having difficulty with her hearing and had difficulty adjusting because of the partial deafness. In 1944 she underwent an operation at the Boston City Hospital for a complete hysterectomy. Since this last operation the patient's vagina closed to such an extent that sexual intercourse was difficult and painful. It was noted in the record that the patient said she was depressed after her operation in 1944, and was beginning to feel better when she received news of her brother's death, and became depressed all over again. Two months before admission to the Boston State Hospital the patient's sister lost a baby. The patient saw the baby's body and has been worrying about it ever since.

The patient's husband, who was the informant in this case, first noticed the patient's odd behavior on April 30, 1946, when the patient expressed the idea that the police were following them. The next day at dinner the patient acted queerly, as if she were going to cry. The next



day they went for a ride and the patient started talking about things that happened thirty years ago, and was thinking she saw people she hadn't seen for years. That night the patient began yelling for the physicians who had performed the operations on her in 1927 and 1944. She raved all night and had to be taken to a mental hospital.

This case is another picture of a person whose physical condition helped to precipitate the onset of the psychosis. The patient first became depressed when she began having difficulty with her hearing and found it hard to adjust to this physical handicap. This difficulty played a significant role in her behavior and general attitude. It took away a great source of pleasure, as she was unable to keep up with sufficient interchange through satisfactory communication with others. The difficulty she had during menstruation also isolated her from children her own age when it became necessary for her to leave school. In a sense it probably left her with feelings of isolation and loneliness. It was noted that the patient became depressed after the hysterectomy was performed, and in all probability this left her with a feeling that now all possibilities of having a child had been done away with. The fact that she later had painful and difficult sexual relations with her husband also caused considerable anxiety and fear, and her sexual desires which were repressed became stirred up and threatened her security. The sight of the body of her sister's baby which depressed the patient so also stirred up unconscious feelings around



day they went for a ride and the patient started talking about things that happened thirty years ago, and was thinking she saw people she hadn't seen for years. That night the patient began yelling for the physicians who had performed the operations on her in 1937 and 1944. She raved all night and had to be taken to a mental hospital.

This case is another picture of a person whose physical condition helped to precipitate the onset of the psychosis. The patient first became depressed when she began having difficulty with her hearing and found it hard to adjust to this physical handicap. This difficulty played a significant role in her behavior and general attitude. It took away a great source of pleasure, as she was unable to keep up with sufficient interchange through satisfactory communication with others. The difficulty she had during menstruation also isolated her from children her own age when it became necessary for her to leave school. In a sense it probably left her with feelings of isolation and loneliness. It was noted that the patient became depressed after the hysterectomy was performed, and in all probability this left her with a feeling that now all possibilities of having a child had been done away with. The fact that she later had painful and difficult sexual relations with her husband also caused considerable anxiety and fear, and her sexual desires which were repressed became stirred up and threatened her security. The sight of the body of her sister's baby which depressed the patient so also stirred up unconscious feelings around



the hysterectomy and the fact that she could not bear children. The combination of these factors including others such as worry, hostility, guilt lead to projections in the form of hallucinations and delusions which occur readily in the setting of insecurity, anxiety and depression, and the patient had to be admitted to a mental hospital.

### Traumatic Experiences

It is the purpose of this section of the chapter to attempt to answer the question, "What types of experiences has the patient had to face prior to admission to the Boston State Hospital?" Keeping in mind such things as: children leaving home for various reasons; death of close relatives; breaking up of home - loss of many protecting factors - living alone.

The question can best be answered by showing the relationship of traumatic experiences to the psychosis.

#### Case VII:

Mrs. J., age fifty-nine, was admitted to the Boston State Hospital on June 4, 1946, and diagnosed as having Involutional Psychosis, Other types. The patient was transferred from the Boston City Hospital where she was suicidal and depressed. She showed marked hypertension, insomnia, delusions of persecution. The physician's certificate states that the patient has been tense and nervous since the death of her son twenty-two years ago. She could not sleep because people about her accused her of bad things - that she is a bum, steals, is no good and is nasty. She has attempted suicide twice.

the hysterectomy and the fact that she could not bear children. The combination of these factors including others such as worry, hostility, guilt lead to projections in the form of hallucinations and delusions which occur readily in the setting of insecurity, anxiety and depression, and the patient had to be admitted to a mental hospital.

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The question can best be answered by showing the relationship of traumatic experiences to the psychosis.

### Case VII:

Mrs. J., age fifty-nine, was admitted to the Boston State Hospital on June 4, 1948, and diagnosed as having involutional psychosis, other types. The patient was transferred from the Boston City Hospital where she was suicidal and depressed. She showed marked hyperreflexia, insomnia, delusions of persecution. The physician's certificate states that the patient has been nervous and nervous since the death of her son twenty-two years ago. She could not sleep because people about her accused her of bad things - that she is a dumb, steals, is no good and is nasty. She has attempted suicide twice.



The patient was born in Italy on June 19, 1886. Very little information about her early childhood was obtained. The patient's parents died of old age. It is not known whether there were siblings. The patient is illiterate. The patient's husband, age sixty-six is a native of Italy. He and the patient grew up in the same town. They had six children. The husband was quick tempered, he and the patient had their family arguments, but the husband has "changed" recently. The patient's family never gave her any cause to worry. She was very changeable; one day she would be happy, then she would become moody and depressed. The patient liked to be with people, and she was friendly with some people. She has been friendly with her friends for over thirty years. She was a good housewife and managed the home well. During the depression the family was getting public relief which made it hard for the patient to raise her six children. Her only fear was that people who were not Italian were against her and wanted to harm her. She liked to crochet and knit. The patient underwent a hysterectomy operation at the Forest Hills Hospital in 1936.

The patient's illness has been coming along ever since her son died in 1922. The patient had five children die in a very short period of time. One daughter was burned to death before the patient's eyes. The patient had the feeling that people were always against her. She was sent to the Boston City Hospital because she attempted suicide, and from that hospital she was admitted to the Boston State Hospital.

This case presents a picture of a woman who has faced many traumatic experiences; before she could get over one tragedy another came directly behind it. The patient never got over the death of her son in 1922 at which time she became depressed and never recovered from the shock of it. This patient harbored hostile feelings toward her environment as shown by her paranoid projections against others. The



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death of her children was influential, directly on her illness, on the basis of deprivation, sorrow and, indirectly, through the anxieties and reflections these events induced with respect to her own safety. She was psychotic and had to be admitted to a mental hospital.

#### Case VIII:

Miss N., age forty-four, was first admitted to the Boston State Hospital on January 19, 1945 with a diagnosis of Involutional Psychosis, Paranoid type. At that time she expressed persecutory ideas and bizarre behavior. She was released after eight months in the care of her sister. From that time to the present admission she has been unable to provide for herself, was unconcerned about this, was suspicious and frequently expressed delusions of persecution.

The patient was readmitted to the Boston State Hospital on February 5, 1947 and the same diagnosis was made. Upon admission she was apathetic, fearful, undernourished, suspicious of everyone. She talked about people taking money from her and acting in this manner to benefit themselves but making no attempt to help her; she was very evasive. She talked about people following her because she was not working. It was stated she had become dependent on the charity of her church and very attached to the church.

The patient was born in New York. Her parents were born in Ireland. Her father, a policeman, died of tuberculosis in New York in 1900; he was described as a strict and temperate man. Her mother died of cancer in 1937; she was described as being very well liked and very religious. There were seven children, two died as babies, an older sister died at age thirty of childbirth, one brother died of pneumonia seven years ago. Another sister is a patient in the Boston State Hospital. The patient was the oldest of the living children. She was very much attached to her mother and dependent on her for everything. The patient was greatly depressed over the death



death of her children was influential, directly on her life, on the basis of deprivation, sorrow and, indirectly, through the anxieties and reflections these events induced with respect to her own safety. She was psychotic and had to be admitted to a mental hospital.

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Miss M., age forty-four, was first admitted to the Boston State Hospital on January 19, 1945 with a diagnosis of Involutional Psychosis, Paranoic type. At that time she expressed persecutory ideas and bizarre behavior. She was released after eight months in the care of her sister. From that time to the present admission she has been unable to provide for herself, was unconcerned about this, was suspicious and frequently expressed delusions of persecution.

The patient was readmitted to the Boston State Hospital on February 5, 1947 and the same diagnosis was made. Upon admission she was apathetic, fearful, undifferentiated, suspicious of everyone. She talked about people taking money from her and acting in this manner to benefit themselves but making no attempt to help her; she was very evasive. She talked about people following her because she was not working. It was stated she had become dependent on the charity of her church and very attached to the church.

The patient was born in New York. Her parents were born in Ireland. Her father, a policeman, died of tuberculosis in New York in 1900; he was described as a strict and temperate man. Her mother died of cancer in 1937; she was described as being very well liked and very religious. There were seven children, two died as babies, an older sister died at age thirty of childbirth, one brother died of pneumonia seven years ago. Another sister is a patient in the Boston State Hospital. The patient was the oldest of the living children. She was very much attached to her mother and dependent on her for everything. The patient was greatly depressed over the death



of her oldest sister and again at the death of her mother, at which time she became severely hysterical. She had been accustomed to having her mother make decisions and plans for her all her life; she was rather seclusive, never suspicious or moody.

Miss N. began school at age six; and left in the eighth grade. After leaving school she worked for six years as a bundle girl in a store; after that she worked for four years as a clerk in a bake shop. Since that time she worked intermittently as a domestic. As a child she was quiet and seclusive; she was interested in religion, and had little to do with the opposite sex. She wanted to be a nun but her mother forbade it. Once she was proposed to but she declined and avoided the man thereafter. The patient spent most of her time reading and going to church. She stopped work to stay at home to take care of her mother. Following the death of her mother in 1937 the patient was supported by the mother's previous earnings and the remainder of her father's pension. However, she and her sister are said to have wasted the money and had to accept relief soon after. Both the patient and her sister misused their welfare money and had trouble with the Department of Public Welfare. Because of their inability to provide and look after themselves, in 1945 the patient was admitted to the Boston State Hospital, and a job was found at the Peter Bent Brigham Hospital for the sister.

This case presents an excellent picture of a person whose difficulty seems to have begun at about the time of her mother's death. Following a brief period, the ensuing sequence of events, namely the squandering of the mother's pension and savings and her welfare checks, showed immature emotional behavior. The patient persisted in not providing for herself which resulted finally in her first admission to a mental hospital. After a short stay and discharge she



of her oldest sister and again at the death of her mother, at which time she became severely hysterical. She had been accustomed to having her mother make decisions and plans for her all her life; she was rather sensitive, never suspicious or moody.

Miss W. began school at age six; and left in the eighth grade. After leaving school she worked for six years as a bundle girl in a store; after that she worked for four years as a clerk in a bank shop. Since that time she worked intermittently as a domestic. As a child she was quiet and sensitive; she was interested in religion, and had little to do with the opposite sex. She wanted to be a nun but her mother forbade it. Once she was proposed to but she declined and avoided the man thereafter. The patient spent most of her time reading and going to church. She stopped work to stay at home to take care of her mother. Following the death of her mother in 1937 the patient was supported by the mother's previous earnings and the remainder of her father's pension. However, she and her sister are said to have wasted the money and had to accept relief soon after. Both the patient and her sister missed their welfare money and had trouble with the Department of Public Welfare. Because of their inability to provide and look after themselves, in 1945 the patient was admitted to the Boston State Hospital, and a job was found at the Peter Bent Brigham Hospital for the sister.

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continued as prior to admission, did not provide for herself, becoming attached to the church, where she manifested bizarre behavior and became dependent on the charity of the church. This lack of insight and judgment into her inadequacies led to the development of compensatory satisfying reactions of vague delusions of persecution, suspiciousness and hostility. This psychotic reaction led to her readmission to a mental hospital.

It is the purpose of the following section of the chapter to attempt to answer the question "In what way do the following social factors influence involutional psychosis:  
a. family and marital maladjustments    b. economic maladjustment?"

#### Family and Marital Maladjustments

In the following two cases, family and marital maladjustment plays an important role in the patient's lives.

##### Case IX:

Mrs. F., age fifty-nine, was admitted to the Boston State Hospital on October 10, 1946, and diagnosed as having Involutional Psychosis Paranoid type. Upon admission she was violent, and noisy, between depression states. According to the physician's certificate the patient admitted she had been depressed and excited, did not remember just what took place. She was not oriented as to the day, month or year. It was

continued as prior to admission, did not provide for herself, becoming attached to the church, where she manifested bizarre behavior and became dependent on the charity of the church. This lack of insight and judgment into her inadequacies led to the development of compensatory satisfying reactions of vague delusions of persecution, suspiciousness and hostility. This psychotic reaction led to her readmission to a mental hospital.

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#### Family and Marital Maladjustments

In the following two cases, family and marital maladjustment plays an important role in the patient's illness.

#### Case IX:

Mrs. F., age fifty-nine, was admitted to the Boston State Hospital on October 10, 1948, and diagnosed as having involutional psychosis, paranoid type. Upon admission she was violent, and noisy, between depression states. According to the physician's certificate the patient admitted she had been depressed and excited, did not remember just what took place. She was not oriented as to the day, month or year. It was



noted that she would scream in her sleep and later claim she knew nothing about her activities. She was rather accusatory toward other persons.

Mrs. F was born in Italy in 1887. She was the youngest of three children, having an older brother and sister. Very little is known of patient's parents. Her father was said to have been "queer" but he had not been hospitalized. The patient came to the United States when she was twelve years old, with her brother, sister and a cousin. She was educated in the United States; the extent of her education is unknown. The sister who was two years older than the patient became ill and returned to Italy, where soon after she gave birth to a child, who is the informant in this case. The sister was placed in a mental hospital and died there. The patient's brother has been dead five years. The patient had a fainting spell at that time.

The patient married her husband, a native of Italy, when she was nineteen years old. They had no children. The patient raised the daughter of the sister who died in Italy. The niece lived with the patient until eight years ago when she was married. The patient's husband is now in Italy. The patient's relationship with her husband seemed to be very tenuous. On three occasions the patient returned to Italy with her husband. The last time was during World War I at which time she stayed four years while her husband served in the Italian army. The patient did not like Italy and she and the husband returned to the United States. In 1930 her husband decided to return to Italy again, insisting that he was not feeling well and that the depression had put him out of a job. The patient at that time refused to go with him, and took a job in a shoe factory in Chelsea. She worked continuously since then to support herself and her niece. She was always considered to worry a great deal, and was described as a somewhat "queer" personality. She was always eager to keep herself busy; was always happiest when working; however, she cried very easily.

When her husband left her, she began to behave in a peculiar manner. When her brother died



noted that she would scream in her sleep and later claim she knew nothing about her activities. She was rather acquiescent toward other persons.

Mrs. F was born in Italy in 1887. She was the youngest of three children, having an older brother and sister. Very little is known of patient's parents. Her father was said to have been "queer" but he had not been hospitalized. The patient came to the United States when she was twelve years old, with her brother, sister and a cousin. She was educated in the United States; the extent of her education is unknown. The sister who was two years older than the patient became ill and returned to Italy, where soon after she gave birth to a child, who is the informant in this case. The sister was placed in a mental hospital and died there. The patient's brother has been dead five years. The patient had a fainting spell at that time.

The patient married her husband, a native of Italy, when she was nineteen years old. They had no children. The patient raised the daughter of the sister who died in Italy. The niece lived with the patient until eight years ago when she was married. The patient's husband is now in Italy. The patient's relationship with her husband seemed to be very tenuous. On three occasions the patient returned to Italy with her husband. The last time was during World War I at which time she stayed four years while her husband served in the Italian army. The patient did not like Italy and she and the husband returned to the United States. In 1930 her husband decided to return to Italy again, insisting that he was not feeling well and that the depression had put him out of a job. The patient at that time refused to go with him, and took a job in a shoe factory in Chelsea. She worked continuously since then to support herself and her niece. She was always considered to worry a great deal, and was described as a somewhat "queer" personality. She was always eager to keep herself busy; was always happiest when working; however, she cried very easily.

When her husband left her, she began to behave in a peculiar manner. When her brother died



five years ago, the patient became wild and accusatory. The patient has several nephews and nieces but had very little contact with them. After her niece married the patient took a room alone. In 1946, the patient called her niece and complained that she was physically ill with heart trouble. She was examined by a private physician who found nothing pathological except possible gall bladder trouble. The patient at that time felt that she was so sick that she would die, consequently the niece had the patient live with her. At that time the patient said she knew her sickness - "man sickness". Soon after this the patient began to look ill. She would sing, and call to her mother and scream. She said she was having dreams about her parents. She became very seclusive and on several occasions was found under the bed. She accused her niece of using her money. The niece had the patient taken to the Bosworth Hospital where she was given electric shock treatments. After this the patient returned to living alone in a room. On visits to her niece she seemed quite rational although she was easily irritated. She was worried about her husband from whom she had not heard in years, and accused her niece of telling her husband that she was in a mental hospital. Recently the patient woke up screaming and the door had to be broken down to quiet her. Her behavior was such that she had to be hospitalized.

This case presents a picture of a patient who was the product of an upbringing in which she had no real parental figures to relate to. She left Italy at an early age with persons not much older than herself. Her marital adjustment had been very poor, her husband and she did not get along; he was intent on living in Italy whether the patient wanted to or not. And she apparently never was able to relate well to anyone. Recently this poor adjustment was added to the burden of loss of a brother, loss of a niece who had been living with her, and the loss of her physical



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stamina. These added burdens have made her adjust with a neurotic, and later with a psychotic reaction.

#### Case X:

Mrs. K., age thirty-nine, was admitted to the Boston State Hospital on May 2, 1946, and was diagnosed as having Involutional Psychosis, Other types. The patient was brought from a rest home by police. Upon admission she was found to be depressed and agitated. She admitted hearing voices in the past. She explained that her main difficulty was that "there is no love in my heart and therefore life is not worth living." She admitted destroying things at the home. The physician's certificate stated that the patient had become excited, irritable and uncooperative. She refused food at intervals; the doctors at the rest home were unable to cope with her and decided to send her to a mental hospital.

Mrs. K. was born in Boston on July 6, 1906. She was the youngest of five children, and the family made a great deal over her. Her mother died of pneumonia at the age of sixty-five in 1925; her father, a freight handler, died of heart trouble at the age of seventy-five in 1935. The family got along well together. The patient attended two years of high school. After that she worked for twenty-two years as a telephone operator for the New England Telephone Company. As a young girl the patient was very seclusive, unable to make friends; she liked dancing. In later life she did not enjoy much of any recreation. She preferred to be alone, was very much wrapped up in herself. She showed signs of temper tantrums at times.

The record states the patient never liked her work as telephone operator. Because she always felt unhappy she thought that if she married her condition would improve. She could find a home, and if she had a child she might feel happier. Therefore she married in 1935; she had a daughter in 1936, and in 1937 she and her husband separated. The patient never loved her husband but she thought a baby would make



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Mrs. K., age thirty-nine, was admitted to the Boston State Hospital on May 2, 1935, and was diagnosed as having Involutional Psychosis, Other types. The patient was brought from a rest home by police. Upon admission she was found to be depressed and agitated. She admitted hearing voices in the past. She explained that her main difficulty was that "there is no love in my heart and therefore life is not worth living." She admitted destroying things at the home. The physician's certificate stated that the patient had become excited, irritable and uncooperative. She refused food at intervals; the doctors at the rest home were unable to cope with her and decided to send her to a mental hospital.

Mrs. K. was born in Boston on July 6, 1905. She was the youngest of five children, and the family made a great deal over her. Her mother died of pneumonia at the age of sixty-five in 1925; her father, a freight handler, died of heart trouble at the age of seventy-five in 1935. The family got along well together. The patient attended two years of high school. After that she worked for twenty-two years as a telephone operator for the New England Telephone Company. As a young girl the patient was very sensitive, unable to make friends; she liked dancing. In later life she did not enjoy much of any recreation. She preferred to be alone, was very much wrapped up in herself. She showed signs of temper tantrums at times.

The record states the patient never liked her work as telephone operator. Because she always felt unhappy she thought that if she married her condition would improve. She could find a home, and if she had a child she might feel happier. Therefore she married in 1935; she had a daughter in 1936, and in 1937 she and her husband separated. The patient never loved her husband but she thought a baby would make



her happy, and only for that reason did she marry. The patient and her husband did not get along. After the patient obtained her legal separation she found a job, and boarded with friends. The patient's daughter never lived with her. The patient had to pay for the child's board elsewhere. She tried to be with the child as often as possible.

This case presents a picture of a patient who had a rather schizoid personality, as was indicated in her being seclusive in childhood and later life. When she left high school she took a job she did not like. She probably had few friends, preferred to be alone, and was generally a very unhappy person who had formed no satisfying relationships with anyone. The patient wanted a home for herself, and thinking a child would make her happy, decided to marry. Being a person who was "wrapped up in herself", and of a frigid nature sexually, the patient did not make a good marital adjustment and after a short time separated from her husband. After obtaining a legal separation the patient had to return to work which necessitated placing her child out to board. All of this was an admission of defeat in that she now had no husband, no home, and a child whom she had to place with another family. With the advent of the climacteric the patient began to realize that she had not obtained all that she had desired out of life and that things had not turned out as she expected. She experienced anxiety and guilt over not having loved her husband, the father of her child. Her own desire for love was shown in her paranoid

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projections around statements that "there is no love in her heart and therefore life is not worth living". There is also an ambivalent feeling for her child. Her guilt, frustration, and anxiety were too much for the patient to bear; her defenses were weakened, and consequently a psychosis developed.

### Economic Maladjustment

In the following case, economic maladjustment played an important role in the patient's life.

#### Case XI:

Mrs W., age fifty, was admitted to the Boston State Hospital on September 4, 1947, and diagnosed as having Involutional Psychosis, <sup>Melancholia</sup>. Upon admission he was agitated, depressed, restless, had vague unsystematized delusions and was self-accusatory. The Wednesday night before admission the patient could not sleep, his wife called the patient's brother who took the patient to the Chelsea Old Soldiers' Home. On Thursday the patient was sent to the Boston State Hospital.

Mr. W. was born in Massachusetts on November 6, 1896. He was the oldest of five children and was considered very dependent. The patient's parents were born in Italy. His mother died in 1940 of a tumor at the age of sixty-seven; his father died in 1944 at the age of eighty. A brother died in the Army in the South-west Pacific a week after the patient's father died. The patient completed six years of school; he did not do very well but later he "went in for quite a bit of self teaching and studied the dictionary". He is a veteran of World War I; and has worked as a shipper, carpenter and painter's helper. He joined the police force in 1920. He was promoted to the rank of sergeant because he studied hard. In 1926 the patient married. He has always got along with his



projections around statements that "there is no love in her heart and therefore life is not worth living". There is also an ambivalent feeling for her child. Her guilt, frustration, and anxiety were too much for the patient to bear; her defenses were weakened, and consequently a psychosis developed.

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wife; they have a son age thirteen. The patient's wife is the boss of the family. During his entire married life the patient took a primary interest in his home. He would go to work, go home and stay home, except for an occasional visit to relatives and friends. He is described as always being a very nervous person who always had to be doing something; he had a vicious temper.

Three years ago the patient was suspended from the police force. He was caught in an irregularity. He changed shifts a half hour early, and was given a tracing down by the Deputy. The patient had to go before a trial board and was suspended for three weeks on charge of negligence. The patient thought the sentence was unjust and he quit the force in a fit of temper. He asked to be retired on one-half pay. He had entertained doubts of his ability for many years although he was an efficient and brave policeman. The patient became moody and rested for only one month. He then secured several inside jobs but he did not enjoy the work. He stopped associating with all of his friends on the police force and gradually began to stay home more and more, never making any attempt to associate with other people. Efforts were made by his wife, the informant in this case, to show him that it was not necessary for him to worry, because although they were not wealthy, there had never been any cause to think they would have to accept relief. After the patient left the police force, there was as much money in the home as when he had been a sergeant. The patient's friends tried to get him to rejoin the police force, as they thought this would eliminate some of his conflicts, but the patient refused to do so. However, all the patient talked about was the police force, the charge of negligence, and his voluntary retirement for it. He was not making a living.

It was noted in the record that the patient admitted to the psychiatrist that he had not told his wife the real reason for his suspension and he worried about it quite a bit. The patient stated that people liked him all right, although they may hate him now, because he did wrong. He is worse than a "rat".

This case presents a picture of a person who had held a



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This case presents a picture of a person who had held a



responsible position for many years, but due to a charge of negligence and a fit of temper, resigned his job. He tried to make an adjustment on several jobs but could not be satisfied. The patient withheld from his wife the real reason for his suspension and this caused him considerable anxiety. It was brought out that he was a very nervous person who had to be doing something all the time. The fact that he was idle a great deal of the time and had considerable time to think brought out a great deal of fear, worry, anxiety and frustration which became harder and harder for him to deal with. Also the fact that he had previously entertained doubts about his ability for many years; and to be idle at this time made him seem a sort of useless individual to others as well as to himself. The patient was ashamed of things as they were after he resigned his job, yet his pride kept him from rejoining the police force; this in turn caused him to worry about the probability of having to accept relief. The patient's defenses were withdrawal and seclusion from his social contacts rather than face what he felt people were thinking about him. His anxiety and guilt were projected in the form of unsystematized delusions of self-accusation and somatic complaints, and he, therefore, had to be admitted to a mental hospital.

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## Chapter V

### SUMMARY AND CONCLUSIONS

The purpose of this thesis has been to make a study of personality and social factors influencing involutional psychosis in patients in middle life and later years and their need for admission to the Boston State Hospital. A study was made of the case records of a group of twenty patients who were admitted to the hospital during a two year period - January 1, 1946 to January 1, 1948, with involutional psychosis.

1. The personality factors influencing involutional psychosis in persons in middle life and later years and the necessity for their admission to the Boston State Hospital seem to include the following:

- a. tendency toward worrying or depression
- b. emotional instability

2. The physical factors which seemed to be related to their diagnosis of involutional psychosis include somatic complaints, and physical stresses which led to a general lessening of mental and physical efficiency.

3. The traumatic experiences influencing involutional psychosis in these persons in middle life and later years

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3. The traumatic experiences influencing involutional psychosis in these persons in middle life and later years



and necessitating admission to the hospital seem to include the following:

- a. children leaving home for various reasons
- b. death of close relatives
- c. breaking up of the home - loss of many protecting factors - living alone

4. Other social factors influencing involutional psychosis in the cases studied seem to include:

- a. family and marital maladjustments
- b. economic maladjustments

Although the number of cases studied represented only a small group, and in some cases the records were incomplete, they have resulted in findings which agree with those of most other authors.

1. Study of the pre-psychotic personalities of this group brought to light an almost universally good energy drive directed to conscientious performance and hard work. Noteworthy was their lack of intimacy in personal relationships and narrowness in their interests. As a group they had few intimate friends and few purely recreational and social relationships. It was found that all of the patients tended toward some degree of emotional instability, as was indicated by such things as tendency toward worrying, temper tantrums, aggressiveness, seclusion, introversion, and inhibition; all of which in the final analysis add up to the

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dynamic factor of insecurity which, as we have seen leads to anxiety.

There are crises of aging with which an individual may be confronted and which may attack his special sensitivity and insecurity; such as, loss of loved ones, family and marital strife, inability to live up to high standards, bewildering sexual factors, etc. The kind of reaction depends on the personality which one has developed from infancy through adult life. In this group it was found that the neurotic defenses which were adequate previous to the involutional period proved to be insufficient for the socio-economic difficulties which the individual had to face when he reached later life and the person reacted psycho-pathologically to those life situations.

2. Many of the patients became ill apparently in response to predominantly physical stresses which, along with other symptoms; such as, insomnia, loss of appetite and hypochondriacal complaints reduced the patients' physical reserve. The most common ailments involved the reproductive organs. Others included deafness, vertigo, coronary thrombosis, hypertension, rupture, curvature of the spine, hardening of the arteries, and thyroid trouble. Many of these types of ailments are signs of organic deterioration within the body and in cases where the physical resistance is very low, equili-

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brium of the mind is upset which before was maintained, and hospitalization becomes necessary.

3. On considering the influence of traumatic experiences preceding the admission of the patients to the hospital it was found that included in the contributing cause, were such factors; as, death of near relatives, concern over emancipation of the children, and financial insecurity. These patients were individuals who had lacked satisfactory self-dependence and consequently were emotionally dependent on their relatives or children; or they were growing old and had not made financial plans for their future, could not orient themselves to the perplexing life situations which presented themselves. The loss of the warmth and protection gained from close personal relationships as well as the material satisfactions obtained from external possessions presents such a threat to the security of these sensitive people that they assume significant proportions and can truly be termed precipitating factors of the psychosis.

4. Other social factors; such as, family and marital maladjustments and economic maladjustments, whether alone or in combination, create situational stresses and worries which tend to play a significant part in precipitating mental illness. Such things as having never been part

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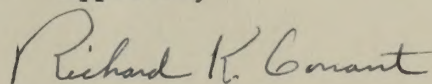
4. Other social factors; such as, family and marital maladjustments and economic maladjustments, whether alone or in combination, create situational stresses and worries which tend to play a significant part in precipitating mental illness. Such things as having never been part



of a real family situation, family friction, desertion of husband, divorce, loss of job, may be included in these social maladjustments. They may be factors which the individuals have withstood for years prior to the involuntional period, but together with the advent of the menopause and other factors which must inevitably enter into the picture, present a situation which is doubly difficult for the patients to bear and their reaction is a psycho-pathological one.

The outstanding factor in the psycho-pathological reactions of the patients studied is insecurity, with confidence shaken in one's personality and physical fitness and in one's ability to deal successfully with socio-economic changes. Insecurity is accompanied by anxiety. The resulting need for greater security leads to protective attitudes, to a readiness to defend what one has obtained, and to caution and indecision. This study agrees with the findings of other authors, namely that in making a study of precipitating causes of a psychosis, the personality, social and physical factors are interrelated, and must be considered together in order to take in the broader aspects of the problem.

Approved,




Richard K. Conant  
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A P P E N D I X A

BIBLIOGRAPHY





## BIBLIOGRAPHY

### Books

Bentley, Madison, The Problems of Mental Disorder. McGraw-Hill Company, 1934.

Deutsch, Albert, The Mentally Ill in America. New York: Doubleday-Doran and Company, 1937.

Deutsch, Helene, Psychology of Women. New York: Grune and Stratton, Incorporated, 1945.

Henderson, D.K., and R.D. Gillespie, A Textbook of Psychiatry. London: Oxford University Press, 1927.

Hunt, J. McVicker, Personality and Behavior Disorders. New York: The Ronald Press, 1944.

Kaplan, Oscar J., Mental Disorders in Later Life. California: Stanford University Press, 1945.

Noyes, Arthur P., Modern Clinical Psychiatry. Philadelphia: W.B. Saunders Company, 1939.

Stieglitz, Edward J., The Second Forty Years. Chicago: J.B. Lippincott Company, 1946.

Strecker, Edward A. and Franklin G. Ebaugh, A Textbook of Psychiatry. London: Oxford University Press, 1927.

### Articles

Hoch, August and John T. MacCurdy, "Prognosis of Involutional Psychosis", American Journal of Psychiatry, 1:433-473, August, 1922.

# BIBLIOGRAPHY

## Books

- Bentley, Madison. The Problems of Mental Disorder. McGraw-Hill Company, 1934.
- Deutsch, Albert. The Mentally Ill in America. New York: Doubleday-Doran and Company, 1937.
- Deutsch, Helene. Psychology of Women. New York: Grune and Stratton, incorporated, 1945.
- Henderson, D.K., and R.D. Gillespie. A Textbook of Psychiatry. London: Oxford University Press, 1937.
- Hunt, J. McVicker. Personality and Behavior Disorders. New York: The Ronald Press, 1944.
- Kaplan, Oscar J. Mental Disorders in Later Life. California: Stanford University Press, 1945.
- Koyes, Arthur P. Modern Clinical Psychiatry. Philadelphia: W.B. Saunders Company, 1939.
- Stieglitz, Edward J. The Second Forty Years. Chicago: J.B. Lippincott Company, 1948.
- Strecher, Edward A. and Franklin G. Baum. A Textbook of Psychiatry. London: Oxford University Press, 1937.

## Articles

- Hoch, August and John T. MacGurby. "Prognosis of Involutional Psychosis". American Journal of Psychiatry. 1:433-473, August, 1932.



22-1072

Name: \_\_\_\_\_

Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Date Admitted: \_\_\_\_\_

Occupation: \_\_\_\_\_

- a. Was subject ever hospitalized?
- b. Length of stay \_\_\_\_\_

Parental History: A P P E N D I X B

SCHEDULE USED IN STUDY

Siblings: \_\_\_\_\_

- a. Number of \_\_\_\_\_
- b. Status of siblings in family \_\_\_\_\_
- c. Relationship between \_\_\_\_\_

Environment: \_\_\_\_\_

Milestones: \_\_\_\_\_

- a. Details of \_\_\_\_\_
- b. Details of \_\_\_\_\_

Marital History: \_\_\_\_\_

- a. Single \_\_\_\_\_ b. Divorced \_\_\_\_\_ c. Widowed \_\_\_\_\_
- d. Married \_\_\_\_\_ e. Separated \_\_\_\_\_ f. Deceased \_\_\_\_\_

No. of times divorced: \_\_\_\_\_

No. of children: \_\_\_\_\_

Sex of children: \_\_\_\_\_

Age of children: \_\_\_\_\_





SCHEDULE

Name: \_\_\_\_\_ Case No. \_\_\_\_\_

Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Citizenship: \_\_\_\_\_

Date Admitted: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Occupation: \_\_\_\_\_

a. Did patient like job held?

b. Length of time on job

Parental History: \_\_\_\_\_

a. Attitude of parents toward patient

Siblings: \_\_\_\_\_

a. Number of

b. Status of patient in family

c. Relationship between patient and siblings

Environment: \_\_\_\_\_

Religion: \_\_\_\_\_

Education: \_\_\_\_\_

a. Extent of

b. Ideals and Aspirations

Marital Status: \_\_\_\_\_

a. Single

c. Divorced

e. Widow

b. Married

d. Separated

f. Widower

No. of times married: \_\_\_\_\_

No. of Children: \_\_\_\_\_

Sex of Children: \_\_\_\_\_

Ages of Children: \_\_\_\_\_





Children living in the home: \_\_\_\_\_

Difficulties in the family: \_\_\_\_\_

- a. with parents
- b. with children
- c. with husband
- d. with relatives

Work History: \_\_\_\_\_

- a. keeping to one job
- b. dependable

Economic Status: \_\_\_\_\_

- a. lower
- b. middle
- c. upper

Physical Condition - past and present

- a. traumatic accidents
- b. operations
- c. "aging factors"
- d. generally poor health

Pre-psychotic personality: \_\_\_\_\_

- a. personality during childhood
- b. adolescent interests
- c. adult recreations and interests (evidences of sociability - warmth and intimacy in personal relationships)
- d. sensitivity
- e. religious attitudes
- f. previous sex adjustment
- g. dependency relationships
- h. noticeable changes in habits or behavior during menopause





i. feelings toward marital partner and children (head of family, education, etc.)

j. aggressive actions toward others

k. mood changes

Make-up of personality: \_\_\_\_\_

a. introverted

b. neurotic

c. dependent

d. passive

e. suspicious

f. irritable

g. meticulous

h. over-conscientious

i. worrisome

j. cheerful

k. depressive

Traumatic experiences: \_\_\_\_\_

a. death of near relative

b. concern over emancipation of children through leaving home for various reasons

c. financial failures making for insecurity, et cetera

Alcoholism and toxic influences: \_\_\_\_\_

Present illness or difficulty: \_\_\_\_\_

a. time of onset

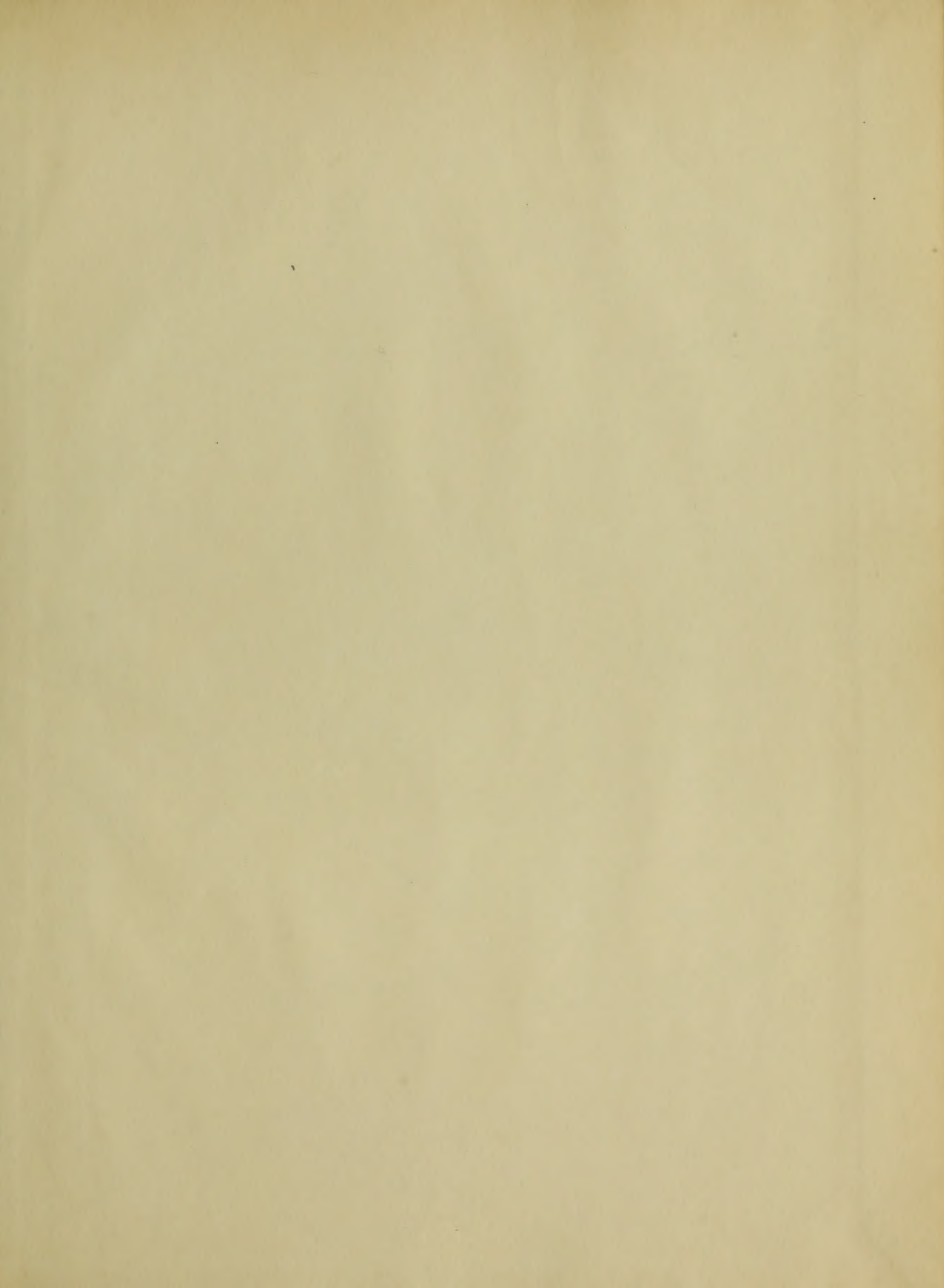
b. nature of first manifestations

c. how they developed

d. how the picture changed

















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